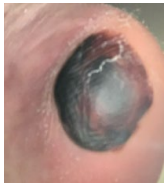
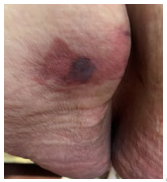
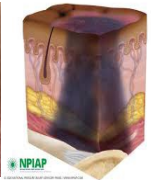

Patient Care plans –Suspected Deep Tissue Injury (SDTI)
Non blanching purple or maroon skin (light-toned skin) Discoloration (Dark skin tones)
Skin can be firmer or soft (boggy) & warmer or cooler than surrounding tissues.
Blood filled blister may also be present with dark wound bed.
SDTI start at bone: tissue interface and develop from inside out.

Grade & Pressure Damage	Expected Outcome	Nursing Care Plan
SDTI present ..... (please document site) **NB If SDTI on foot of a diabetic patient or known PAD If the tissue becomes hard and necrotic then will require IMMEDIATE specialist management / advice from GP/ Vascular/ Deibetologist or Podiatry** **IR1(acute/primary) Must be completed. IR1 No……** **Care Homes complete appropriate adverse event reporting documentation.** **Complete TVS referral form and wound photograph sent to TVS mailbox. Date sent……**	To prevent further pressure damage occurring. To provide appropriate wound treatment plan, in the aim to promote wound healing. To document evidence of skin checks/inspection to prevent any further deterioration. Ensure pressure damage is graded by using the Scottish Adapted European Pressure Ulcer Advisory Panel's Grading tool and record in patients notes https://nhsforthvalley.com/wp-	1.Complete daily Risk Assessment and ensure treatment / re assessment is in accordance with local guidelines and patient risk. (Braden, Waterlow/ Must) 2.Supply Patient Pressure Area Care Leaflet to Patient/Resident/Family/Carers. https://nhsforthvalley.com/wp-content/uploads/2021/12/PAC-Patient-Information-Leaflet.pdf 3.Assess skin (as per local polices), with particular emphasis on bony prominences or risk areas by using the fingertip test and record any findings in clinical/nursing notes. https://nhsforthvalley.com/wp-content/uploads/2021/12/Single-Finger-Test-Pocket-Guide.pdf 4. Ensure that pressure ulcers(s) present are graded using the Scottish Adapted European Pressure Ulcer Advisory panel grading tool, and record in patients records. 5. Ensure off loading pressure relieving equipment is implemented (i.e mattresses, heel protectors, cushions)and document what equipment is utilised. Please state..... 6. IMMEDIATE implementation of pressure relieving regime as per best practice/pressure area standards and document in care & comfort charts/turning charts and clinical nursing notes. https://nhsforthvalley.com/wp-content/uploads/2020/05/Pressure_Ulcer_Risk_Assessment__Prevention_Guideline-Updated-Version-1-May-2020_final.pdf 7.Wound Assessment Charts and Treatment Plan must be fully completed. https://nhsforthvalley.com/wp-content/uploads/2018/05/Wound-Management-Formulary.pdf **SDTI unbroken skin:** Please ensure any mechanical load is off loaded with use of pressure relieving

Patient/relatives informed of pressure injury. **Date.....** **SDTI to heels, referral to orthotics for off loading foot wear.** **Date.....**	content/uploads/2019/10/GRADING-AND-MOISTURE-TOOL.pdf	equipment and strict 2 hourly pressure area care regime is in place. If mobile and pressure damage is to Patient's heel, please refer to Orthotics for off loading pressure relieving boot. https://staffnet.fv.scot.nhs.uk/departments/wp-content/uploads/sites/16/2020/11/ORTHOTIC-REFERRAL-FORM.docx Ensure skin is hydrated with the use of emollients **SDTI with blood filled blister:** Apply Atruaman non adherent dressing, emollient to surrounding skin to rehydrate, chose secondary dressing from below. Aim to keep intact to encourage reabsorption **SDTI with burst blood filled blister:** Cleanse area with Prontosan soak for 5 mins Apply Cavilon barrier film wand to periwound skin. Apply Prontosan Wound Gel X to area. Apply Atruaman non adherent dressing, choose secondary dressing from below. Aim to redress 3 x weekly **Secondary dressings:** Heels: absorbent dressing (soft swabs/super absorbent depending on exudate levels), protection of periwound skin with barrier films, hydration of skin with emollients, secure with Comfinette, Lantor and crepe bandage toe to knee) Secondary adhesive dressings: Low/moderate exudates: Kliniderm foam silicone border dressing (for sensitive skin only) or formulary equivalent. Moderate/high exudate: Tegaderm foam adhesive or formulary equivalent. (avoid using adhesive dressings on heels as this might cause trauma on removal) Continence status must be considered when choosing appropriate secondary dressing for sacral area damage then Viscopaste pad can be used as an alternative in this case to secure primary dressings i.e. Prontosan Wound Gel X dressings remain in place. **Any** deterioration **of skin with necrotic tissue** is documented and recorded in clinical notes. This pressure damage will now be classed as, an **Ungradable PU- please follow Pre formed Pressure ulcer Care plan for Ungradable PU.** 8. Assess and document pain score and provide appropriate analgesia if required.